Commonwealth Of Kentucky

Health Insurance/Flexible Spending Application

(*for Use By Agencies in the State Payroll System - UPPS*)

MUST BE COMPLETED BY THE INSURANCE COORDINATOR

Insurance Effective Date ☐☐ / ☐☐ / ☐☐☐☐ **Company Number** ☐☐☐☐☐

Home County ☐☐☐ **Work County** ☐☐☐ **Contiguous County** ☐☐☐

☐ **< Dual Employee Code**

Reason for Application

☐< New Employee ☐< New Group ☐< COBRA ☐< FSA Only ☐< Other

☐< Open Enrollment ☐< Move Out of Service Area* ☐< Previously Waived**

* If Moving Out of the Service Area, enter the Qualifying Event Date: _____

** If you Previously Waived, enter the Qualifying Event Date AND a description of the Qualifying Event: _____ Date _____ Description

SECTION I: DEMOGRAPHIC INFORMATION

PLEASE PRINT

SSN ☐☐☐-☐☐-☐☐☐☐

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐ (Month / Day / Year)

Name (First, MI, Last)

Gender: ☐< Male ☐< Female

Marital Status: ☐< Married ☐< Single

Street Address

PO Box / Apt. #

City, State, Zip Code

County of Residence

Country/Mail Code -- If NOT U.S.A.

Hire Date (/ /)

Employer Name

Policyholder's Daytime Phone Number ( ) -

SECTION II: PLAN SELECTION

1. County of Coverage	2. Plan Code	3. Option	4. Level of Coverage	5. Payment	6. Cross-Reference ***	7. PCP Selection
Check only one ☐< Home ☐< Work ☐< Contiguous Name of County of Coverage	☐☐☐ *If waiving coverage, enter 999 and go to Section VI.*	☐< A ☐< B	☐< Single ☐< Parent Plus ☐< Couple ☐< Family	☐< Monthly ☐< Twice Monthly *If none selected, you will be set up for Twice Monthly*	☐< Yes *See below table in Section IV*	PCP# -- *If required by Carrier* Are you a current patient? Yes ☐ No ☐

SECTION III: PRIOR HEALTH COVERAGE

Have you, or any eligible dependent, been covered by a health insurance plan during the twelve months prior to this coverage going into effect? Yes ☐ No ☐

If yes, provide the following information. This information will be used to determine waiting periods for pre-existing conditions.

Type of Coverage: ☐< Group ☐< Individual ☐< COBRA ☐< Medicare ☐< Medicaid

Level of Coverage: ☐< Single ☐< Parent Plus ☐< Couple ☐< Family

Insurance Company Name

Name of Employer Providing Coverage (If group policy)

Effective Date (/ /)

Termination Date (/ /)

SECTION IV: SPOUSE AND/OR DEPENDENT INFORMATION

Social Security Number	Name (First, MI, Last)	Gender *Circle One*	Date Of Birth (MM/DD/YYYY)	Rel. Code	PCP # *(If required)*	Current Patient? *Circle One*
		M F				Y N
		M F				Y N
		M F				Y N
		M F				Y N
		M F				Y N

***TO BE COMPLETED BY THE SPOUSE'S INSURANCE COORDINATOR *(Only needed if this is a Cross-Reference application)*:**

Spouse's Company Number (REQUIRED) --> ☐☐☐☐☐

Spouse's Dual Employee Indicator, if applicable --> ☐